CMS Medicare FFS Provider e-News

Brought to you by the Medicare Learning Network®

CMS asks that you share the following important information with all of your association members and state and local chapters.

This issue of the e-News will be available in PDF format within 24 hours of its release in the archive with other past issues.

The e-News for Thursday, October 11, 2012

National Provider Call: In-depth Overview of Stage 2 Clinical Quality Measures for the Medicare and Medicaid EHR Incentive Programs for Eligible Professionals — Registration Now Open [↑]

Wednesday, October 24; 12:30-2pm ET

This call will give eligible professionals an in-depth overview of clinical quality measures (CQMs) included in the final rule for Stage 2 of Meaningful Use for the

Electronic Health Record (EHR) Incentive Programs. Details on the measures, the recommended core set for reporting purposes, and the upcoming release of the 2014 electronic specifications for the EHR Incentive Programs will be provided. Participants will be given an opportunity to engage CMS subject matter experts with questions on Stage 2 CQMs.

Target Audience: Professionals Eligible for the Medicare and Medicaid EHR Incentive Programs. More information can be found in the "Eligibility Requirements for Professionals" section of the Getting Started webpage.

Agenda:

- Review background information on the EHR Incentive Program: Meaningful Use
- Present Stage 2 requirements, focusing on clinical quality measures
- Explain components of eMeasures in Stage 2
- Provide additional resources for more information
- Question and answer session

Registration Information: In order to receive call-in information, you must register for the call on the CMS Upcoming National Provider Calls registration website. Registration will close at 12pm on the day of the call or when available space has been filled; no exceptions will be made, so please register early.

Presentation: The presentation for this call will be posted prior to the call on the FFS National Provider Calls web page. In addition, a link to the slide presentation will be emailed to all registrants on the day of the call.

Continuing education credit may be awarded for participation in certain CMS National Provider Calls. Visit the Continuing Education Credit Notification web page to learn more.

National Provider Call: Preparing Physicians for ICD-10 Implementation — Register Now [↑]
Thursday, October 25; 1:30-3pm ET

HHS has announced the final rule that delays the ICD-10 compliance date from October 1, 2013 to October 1, 2014. Now is the time to prepare.

During this ICD-10 National Provider Call, Dr. Ginger Boyle, a practicing family physician who has developed a coding education program for Spartanburg Regional Healthcare System (SRHS) and its family practice residency program, will share her success and some practical advice about the SRHS transition to ICD-10. CMS subject matter experts will also present the latest information and updates from their areas, followed by a question and answer session.

Agenda:

- Transitioning to ICD-10: practical pointers for providers
- Overview of ICD-10 implementation requirements
- Plans for Local Coverage Determination (LCD) and National Coverage Determination (NCD) ICD-10 conversions
- National implementation issues and plans
- Question and answer session

Target Audience: Medical coders, physicians, physician office staff, nurses and other non-physician practitioners, provider billing staff, health records staff, vendors, educators, system maintainers, laboratories, and all Medicare FFS providers

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Presentation: The presentation for this call will be posted prior to the call on the FFS National Provider Calls web page. In addition, a link to the slide presentation will be emailed to all registrants on the day of the call.

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CMS will post links on the October 25 National Provider Call detail web page to the written transcript, audio recording, and a video slideshow presentation as they become available. A listserv message will announce the availability of these post call materials.

Special Open Door Forum Series: IRF Quality Reporting Program [↑]
Thursday, October 18; 1-2:30pm ET

Please join us for our fourth out of a 4 part series of Inpatient Rehabilitation Facility (IRF) Quality Reporting Program Special Open Door Forums. The purpose of these Open Door Forums is to address issues related to the upcoming implementation of the IRF Quality Reporting Program.

IRF Special Open Door Forum Topics:
Topics to be discussed at this IRF Special Open Door Forum will include (but are not limited to):

- In-depth review of the different helpdesks that are available to IRFs:
  - Names and contact information for each helpdesk associated with the IRF Quality Reporting Program
  - Description of the types of issues each helpdesk can handle
  - Examples of questions that are appropriate for each helpdesk
- An overview of the appeal process that will be available to IRFs, if they receive notice that they have been found to be non-compliant with requirements of the ACA section 3004 IRF Quality Reporting Program
- How to properly report pressure ulcer data to CMS:
  - How to assess IRF patients for pressure ulcers
  - An overview of the Quality Indicator section of the IRF-PAI
  - How to properly document pressure ulcer data in the Quality Indicator section of the IRF-PAI
- How to report CAUTI data to NHSN
- Discussion of the "IRF Frequently Asked Questions"
- Question & Answer sessions to follow the presentation

Special Open Door Participation Instructions:

- Phone Number: 800-603-1774; Conference ID: 25077187
- Note: TTY Communications Relay Services are available for the Hearing Impaired. For TTY services dial 7-1-1 or 800-855-2880. A Relay Communications Assistant will help.

A transcript and audio recording of this Special ODF will be posted to the Special Open Door Forum website and will be accessible for downloading.

For automatic emails of Open Door Forum schedule updates (E-Mailing list subscriptions) and to view Frequently Asked Questions please visit the Open Door Forum website.

CMS Recognizes October as National Breast Cancer Awareness Month [↑]

Breast cancer is the most frequently diagnosed non-skin cancer in women and is second only to lung cancer as the leading cause of cancer-related deaths among women in the United States. Medicare provides coverage for an annual screening mammogram for all female beneficiaries aged 40 or older, as well as coverage for one baseline mammogram for female beneficiaries between the ages of 35 and 39.

What Can You Do?
As a health care professional who provides care to patients with Medicare, you can help protect the health of your Medicare patients by talking with them about the importance of regular mammography screening and encouraging them to take advantage of Medicare-covered screening mammograms, as appropriate for them.

Resources from the MLN for Healthcare Professionals:

- The Guide to Medicare Preventive Services for Healthcare Professionals (see Chapter 8)
- Medicare Preventive Services Quick Reference Information Chart
- Screening and Diagnostic Mammography

Other Resources for Healthcare Professionals:

- Breast Cancer Prevention- National Cancer Institute
- National Breast Cancer Foundation, Inc.
- CDC Breast Cancer Awareness website

Vaccination is the Best Protection Against the Flu — Influenza Vaccine Prices Are Now Available [↑]

Each office visit is an opportunity to check your patients' seasonal influenza (flu) and pneumonia immunization status and to start protecting your patients as soon as your 2012-2013 seasonal flu vaccine arrives. Ninety percent of flu-related deaths and more than half of flu-related hospitalizations occur in people age 65 and older. Seniors also have an increased risk of getting pneumonia, a complication of the flu. Remind your patients that seasonal flu vaccinations and a pneumococcal vaccination are recommended for optimal protection. Medicare provides coverage for one seasonal influenza virus vaccine per influenza season for all Medicare

beneficiaries. Medicare generally provides coverage of pneumococcal vaccination and its administration once in a lifetime for all Medicare beneficiaries. Medicare may provide coverage of additional pneumococcal vaccinations based on risk or uncertainty of beneficiary pneumococcal vaccination status. Medicare provides coverage for these vaccines and their administration with no co-pay or deductible. And don't forget to immunize yourself and your staff. *Know what to do about the flu.*

Remember – Influenza vaccine plus its administration and pneumococcal vaccine plus its administration are covered Part B benefits. Influenza vaccine and pneumococcal vaccine are NOT Part D-covered drugs. CMS has posted the 2012-2013 Seasonal Influenza Vaccines Pricing. You may also refer to the MLN Matters® Article #MM8047, "Influenza Vaccine Payment Allowances - Annual Update for 2012-2013 Season."

For more information on coverage and billing of the flu vaccine and its administration, please visit the CMS Medicare Learning Network® Preventive Services Educational Products and CMS Immunizations web pages. And, while some providers may offer the flu vaccine, others can help their patients locate a vaccine provider within their local community. HealthMap Vaccine Finder is a free, online service where users can search for locations offering flu vaccines.

The ICD-10 Planning Checklist [↑]

With the ICD-10 transition deadline set for *October 1, 2014*, providers, payers, and vendors need to focus on planning their ICD-10 transitions. Below is a checklist of essential planning activities.

The ICD-10 Planning Checklist
Whether you've already started or are just beginning your ICD-10 transition, you will need to thoughtfully plan for the transition and then communicate those strategies to internal staff and external partners. Below are a few steps to help guide your planning process:

- Seek Resources on the ICD-10 transition. CMS and professional and membership organizations have developed information and resources to guide you through ICD-10 implementation.
- Establish an ICD-10 Project Team. This team will be responsible for overseeing the ICD-10 transition, and will vary based on the size of your organization. Larger practices should have a team with representatives from different departments (e.g., executive leadership, physicians, and IT). Smaller practices may only have one or two individuals responsible for helping the practice make the switch to ICD-10.
- Develop an ICD-10 Communication and Awareness Plan. This plan will map out how your organization will communicate with internal staff and external partners about ICD-10 throughout the transition.
- Revisit and Revise Your Implementation Timeline. Since the ICD-10 compliance deadline is now October 1, 2014, your timeline for ICD-10 implementation activities will need to be updated.
- Share Your Implementation Plans and Timelines. Discuss the new ICD-10 compliance deadline and share your revised implementation plans and timelines with internal staff and external partners to ensure transition activities are coordinated.

Share Best Practices and Lessons Learned
Communication and collaboration will help organizations as they transition to ICD-10. As you continue planning, share lessons learned and best practices with others in your area. You can do this through organization newsletters and social media as well as at conferences, workshops, and other educational events. Remember, ICD-10 will affect everyone currently using ICD-9 codes.

Keep Up to Date on ICD-10.
Please visit the ICD-10 website for the latest news and resources to help you prepare.

New Process for Beneficiary Name/Number Mismatches [↑]

CMS has implemented a change in how it handles name and number mismatches. In the past when a claim was submitted with a beneficiary name that did not match the name associated with the Health Insurance Claim Number (HICN) in CMS records, CMS assumed that the submitter made a mistake in listing the name. Accordingly, when the contractor returned the claim, it returned the name of the beneficiary that was associated with that HICN. If the submitter entered the wrong HICN, this could have resulted in the submitter receiving information belonging to a beneficiary the provider had not treated. If this happens in the future, the provider will instead receive the name it originally submitted with the claim.

As part of this change, CMS will no longer perform name searches. A name search used to occur where there was a name number mismatch and the system looked for a slight variation of the name, such as a switch of adjoining letters. In other words, a claim may have been processed even though the information submitted with the claim was not an exact match with CMS records. In the future, such claims will be returned. If that occurs, the provider will need to verify the beneficiary's entitlement information, correct its records and resubmit the claim.

From the MLN: "Contractor Entities At A Glance: Who May Contact You About Specific CMS Activities" Educational Tool – Revised [↑]

The "Contractor Entities At A Glance: Who May Contact You About Specific Centers for Medicare & Medicaid Services (CMS) Activities" Educational Tool (ICN 906983) was revised and is now available in downloadable format. This educational tool is designed to provide education on the definitions and responsibilities of entities who are involved claims adjudication activities. It includes a chart that outlines each entity by type, definitions, responsibilities, and reasons for contacting providers, especially Fee-For-Service providers.

From the MLN: "Advance Beneficiary Notice of Noncoverage Part A and Part B" Booklet — Revised [↑]

The "Advance Beneficiary Notice of Noncoverage Part A and Part B" Booklet was revised and is now available in hard copy format. This booklet is designed to provide education on the Advance Beneficiary Notice (ABN). It includes information on when an ABN should be used and how it should be completed.

To access a new or revised product available for order in hard copy format, go to MLN Products and click on "MLN Product Ordering Page" under "Related Links" at the bottom of the web page.

From the MLN: "The Basics of Medicare Enrollment for Physicians Who Infrequently Receive Medicare Reimbursement" Fact Sheet—Revised [↑]

"The Basics of Medicare Enrollment for Physicians Who Infrequently Receive Medicare Reimbursement" Fact Sheet (ICN 006881) was revised and is now available in downloadable format. This fact sheet is designed to provide education on general Medicare enrollment information for those physicians who are required to

enroll in Medicare for the sole purpose of certifying or ordering services for Medicare beneficiaries. It includes information on frequently asked questions and resources.

Check out CMS on:

#CMSMLN

More helpful links…

The Medicare Learning Network

Archive of Provider e-News Messages